ENROLLMENT/CHANGE REQUEST FORM

DELTA DENTAL PLAN OF MAINE
DELTA DENTAL PLAN OF NEW HAMPSHIRE
DELTA DENTAL PLAN OF VERMONT

PLEASE PRINT OR TYPE - IN BLUE OR BLACK INK ONLY

Please mail to:
VACE Insurance Program
PO Box 810
Montpelier, VT 05601-0810
Telephone: 802-229-2231
Fax: 802-223-4257
E-mail: vacehealth@vtchamber.com

❶ EMPLOYEE INFORMATION

LAST NAME |__|__|__|__|__|__|__|__|__|__|__| (11 CHARACTERS ONLY) FIRST NAME |__|__|__|__|__|__|__|__| (8 CHARACTERS ONLY) BIRTHDATE |___|___|___| MO DAY YEAR

SOCIAL SECURITY # |__|__|__|-|__|__|-|__|__|__|__|

SEX ☐ M ☐ F

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ LEGALLY SEPARATED ☐ WIDOWED

ADDRESS ____________ CITY ____________ STATE ________ ZIP ________

TELEPHONE # ( ) ____________ DATE OF HIRE ____________ DATE OF REHIRE ____________

EMPLOYER NAME ____________ ADDRESS ____________

GROUP NUMBER 7151 **SUBLOCATION NUMBER** 1001 **EFFECTIVE DATE** ____________

❷ REASON FOR APPLICATION (CHECK APPROPRIATE BOXES) ☐ ADD ☐ DELETE

☐ NEW
☐ ANNUAL OPEN ENROLLMENT
☐ CHANGE OF NAME/ADDRESS
☐ CHANGE OF STATUS

EXACT DATE OF EVENT: ____________

CHANGE IN STATUS DUE TO:

☐ MARRIAGE
☐ BIRTH
☐ ADOPTION
☐ SPOUSE'S EMPLOYMENT CHANGE
☐ NO LONGER DEPENDENT FOR IRS PURPOSES
☐ RETIREMENT
☐ DIVORCE
☐ LEGAL SEPARATION
☐ DEATH
☐ OTHER ____________

NOTE: IF ENROLLING ONE ELIGIBLE DEPENDENT, ALL MUST BE ENROLLED. IF ENROLLING DEPENDENT CHILDREN OVER 19 PLEASE INDICATE NEXT TO NAME IF DEPENDENT IS A STUDENT OR INCAPACITATED.

❸ DEPENDENT INFORMATION NOTE: LIST ONLY DEPENDENTS FOR WHOM CHANGE OF STATUS IS REQUESTED

LAST NAME	FIRST	INITIAL	SEX	BIRTH DATE	RELATIONSHIP

❹ TYPE OF COVERAGE (PLEASE CHECK ONE)

☐ 1 - EMPLOYEE ONLY ☐ 2 - EMPLOYEE & SPOUSE ☐ 3 - EMPLOYEE, SPOUSE & CHILDREN
☐ 5 - EMPLOYEE & CHILD ☐ 6 - EMPLOYEE & CHILDREN

❺ PREVIOUS/EXISTING COVERAGE

WILL THIS DENTAL COVERAGE REPLACE ANOTHER NORTHEAST DELTA DENTAL PLAN? ☐ YES ☐ NO

IF YES, GROUP NO. ____________ SOCIAL SECURITY NO. OF PERSON COVERED ____________

WILL YOU OR ANY OF YOUR FAMILY MEMBERS HAVE DENTAL COVERAGE FROM ANOTHER DENTAL PLAN? ☐ YES ☐ NO

IF YES, NAME OF THE INSURER ____________ POLICY NO. ____________

EFFECTIVE DATE OF PLAN ____________ ☐ SINGLE ☐ TWO PERSON ☐ FAMILY

THIS INFORMATION IS REQUIRED SO THAT DELTA MAY COORDINATE BENEFITS WITH THE OTHER CARRIER SO THAT YOU MAY BENEFIT FROM DUAL COVERAGE.

❻ I CERTIFY THAT ALL INF ORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. ALSO, I UNDERSTAND THAT THE EFFECTIVE DATE AND TERMINATION DATE OF MY MEMBERSHIP WILL BE DETERMINED BY MY EMPLOYER OR PLAN SPONSOR IN ACCORDANCE WITH THE UNDERWRITING GUIDELINES OF NORTHEAST DELTA DENTAL. IF MY EMPLOYER OR PLAN SPONSOR REQUIRES EMPLOYEE CONTRIBUTIONS FOR THIS COVERAGE I AUTHORIZE THE DEDUCTIONS OF THESE AMOUNTS FROM MY WAGES. I UNDERSTAND THAT MY DEPENDENTS MUST REMAIN ENROLLED AND BE DROPPED ONLY DURING CONTRACT REOPENING, EXCEPT IN THE EVENT OF FAMILY STATUS CHANGE.

SIGNATURE ____________ DATE ____________

White Copy - DELTA **Canary Copy - EMPLOYER**

(06/03)